STATE OF UTAH INSURANCE DEPARTMENT
REPORT OF MARKET CONDUCT EXAMINATION
of

HUMANA INSURANCE COMPANY

1100 Employers Boulevard

De Pere, WI 54115

NAIC Company Code Number: 73288

As of
December 31, 2017

(Filed 3/13/2020)

TABLE OF CONTENTS

SUBJECT	PAGE
FOREWORD	2
SCOPE OF EXAMINATION	2
EXECUTIVE SUMMARY	2
EXAMINATION FINDINGS	4
SUMMARY	18
ACKNOWLEDGMENT	21

March 13, 2020

The Honorable Todd E. Kiser, Insurance Commissioner
Utah Insurance Department
State Office Building, Suite 3110
Salt Lake City, Utah 84114

In accordance with your instructions, a limited examination has been made of market conduct practices of

HUMANA INSURANCE COMPANY
De Pere, Wisconsin

a life, health, and accident insurance company, hereinafter referred to as the Company, as of December 31, 2017. The report of such examination is herein respectfully submitted.

FOREWORD

The market conduct examination report is, in general, a report by exception. Reference to the Company's practices, procedures, or files subject to review may be omitted if no improprieties are encountered by the examiner.

SCOPE OF EXAMINATION

This limited scope target examination was conducted by examiners representing the Utah Insurance Department in accordance with the Market Regulation Examination Handbook of the National Association of Insurance Commissioners and Utah Code Annotated (U.C.A.) 31A-2, Administrations of the Insurance Laws. The period covered by the examination was January 1, 2015 to December 31, 2017.

The purpose of the examination was to determine the Company's compliance in claims and mental health parity. The scope of this examination included a review of the following areas:

- Company Operations and Management
- Claims
- Utilization Reviews
- Provider Relations
- Marketing and Sales
- Pharmacy Review
- Mental Health Parity

The examiners made an onsite visit May 21, 2018 to May 24, 2018 at the Company location in Louisville, KY. The examiners met with numerous Company personnel, both individually and in group meetings, to learn about Company processes and procedures. The examiners also conducted onsite claim file reviews.

EXECUTIVE SUMMARY

The examination was accomplished through reviewing material related to the Company's files, material related to processes and procedures, pharmacy formularies, interviews, an onsite visit and responses to the coordinator's handbook, information requests and findings. Material was examined for compliance with Utah statutes and the rules from the Utah Administrative Code.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from Company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Company Operations and Management

Information was received and reviewed relating to the basic history and organization of the Company. During the examination, errors were noted for lack of cooperation in the examination and failure in management of the Company IT systems.

Claims

The Company was requested to provide processes, procedures and several claim related universes for testing.

The Company was requested to provide all medical and surgical claims and mental health and substance use disorder claims during the examination period. Review of random samples of the paid and denied claims from these universes revealed errors where the Company failed to provide the following: explanation of benefits, parity and proper notice in a post-service claim. In addition, the Company made multiple requests for the same medical records.

The Company was requested to provide a list of all mental health and substance use disorder pharmacy claims. Review of these random samples of paid and denied claims revealed an error for the Company failing to adopt and implement reasonable standards for the prompt investigation and processing of a claim.

The Company was also requested to provide a listing of claims during the examination period where the Company requested repayment from the provider. An error was noted in this review for untimely notification to the provider.

Utilization Review

The Company was requested to provide processes, procedures and universes of all utilization review files for both medical and surgical claims and mental health and substance use disorder claims. Review of a random and proportional sample of files from these universes revealed a general business practice error for the Company failing to provide proper notice to the claimant of the insurer's benefit decision. An error is also noted for failing to send a resolution letter referencing the correct number of days that treatment was authorized.

Provider Relations

The Company was requested to provide processes, procedures and other information related to provider relations. No errors were noted.

Marketing and Sales

The Company was requested to provide advertising, marketing and sales material including the Summary of Benefits and Coverage for the seventeen products sold during the examination period. After examining the Company products, errors were noted for the Company failing to

maintain proper forms relating to parity. In addition, the Company made communications that contained false, misleading or inaccurate insurance related information to consumers and the Commissioner. The Company was also found to have issued erroneous coverage letters and erroneous group premium notices.

Pharmacy Review

The Company was requested to provide information relating to pharmacy and parity including formularies, protocols, tier structure, drug comparisons, utilization management and other information. Errors were noted relating to violations of parity in attention-deficit/hyperactivity disorder (ADHD) medications, opioid treatment medications and atypical antipsychotics.

Mental Health Parity

The Company was requested to provide processes, procedures, claim universes and other information related to parity between mental health and substance use disorder benefits and medical and surgical benefits.

A review of random samples of paid and denied mental health and substance use disorder claims revealed no errors in the file reviews.

The examiners also tested how the Company treated insureds across the board with other types of claims in associated files for implications relating to parity for mental health and substance use disorder claims. While no implications for issues specifically related to mental health parity were noted, errors are noted for the Company failing to provide resolution letters referencing the correct number of days that treatment was preauthorized.

Management Recommendations

The examiners also noted areas of concern in a separate management letter. While not errors, the examiners recommend that the Company implement procedures that ensure best practices. These involve procedures to ensure that policies are properly worded to prevent inconsistencies, proper contact takes place with providers for pre-authorization procedures and parity requirements for pharmacy benefits are properly tested and documented.

EXAMINATION FINDINGS

Company Operations and Management:

Humana Insurance Company is a Wisconsin life and health insurer. It is one of many subsidiaries of Humana, Inc., a Delaware holding company.

Humana Insurance Company was initially organized on December 18, 1968 under the name Classified Life Insurance Company, which was acquired by Wisconsin Employers Group, Inc. in 1977. The name of the company was changed to Wisconsin Employers Insurance Company effective January 26, 1977. American Express purchased the company in 1983 and changed the company's name to Fireman's Fund Employers Insurance Company effective May 25, 1983. Lincoln National Corporation purchased the company in 1986 and changed the company's name to Employers Health Insurance Company. Lincoln National Corporation eventually formed a company called EMHPESYS Financial Group, Inc. to act as a holding company for Employers Health Insurance Company and related affiliates.

On October 10, 1995, the stock of EMPHESYS Financial Group, Inc. was purchased by Humana Inc. Effective December 31, 2001, Humana Insurance Company, a then existing Missouri life and health insurance subsidiary of Humana, Inc., merged with Employers Health Insurance Company. Employers Health Insurance Company survived the merger and simultaneously changed its name to Humana Insurance Company.

The Company reports Utah premium as follows:

Earned Premiums by A&H Description	**2017**	**2016**	**2015**
individual comprehensive major medical	$-180,437	$28,975,291	$39,367,007
small group - comprehensive major medical	$5,722,252	$13,007,988	$14,373,475
large group - comprehensive major medical	$5,323,708	$3,184,198	$4,586,541
Medicare supplement individual	$1,879,121	$1,801,656	$1,752,112
limited benefit – group	$270,234	$177,448	$181,317
limited benefit – individual	$160,339	$188,222	$202,385
dental group	$365,482	$338,893	$82
dental individual	$528,910	$741,717	$421,276
Medicare group	$544,826	$1,112,327	$2,127,846
Medicare individual	$15,413,438	$20,376,036	$24,827,359
Medicare individual PDP	$20,276,681	$22,534,996	$20,680,172
supplemental health	$691	$654	$3,060
life group	$389,472	$463,055	$473,745
life individual	$50,121	$67,038	$77,121
Total	**$50,744,838**	**92,969,520**	**$109,073,499**

Finding 1:

The Coordinator's Handbook is dated February 19, 2018 with a requested deadline for material of March 9, 2018. Little, if any, material was provided by the deadline. The Company also failed to timely schedule a pre-examination call requested by the examiners. The Company failed to comply with reasonable requests by the examiners and the untimely responses delayed the examination. This is a violation of Utah Code Annotated § 31A-2-204(5)(a) & (b) and Utah Administrative Code R590-

192-11(1).

Recommendation: The examiners recommend procedures be implemented to ensure that the Company cooperates with examiners.

Finding 2:

The examination revealed various IT glitches or coding errors resulting in a showing of systemic failure in the management of the Company IT systems.

A. Mental health and substance use disorder claims that were coded for Medicare and Medicaid should not have been paid under commercial policies. These claims are typically referred to as the "H" code by the Company. However, due to a systemic error in miscoding by the Company IT function, payments were made over this code. The Company then sought reimbursement from providers in many, if not all cases. The following claim numbers are reported by unique claim file numbers (may have multiple lines):

Number of medical and surgical claims	275, 807
Number of mental health and substance use disorder claims	44, 762
Total number of claim overpayments	17, 040*
Number of medical and surgical overpayments	15, 529
Number of mental health and substance use disorder claims overpayments	9, 219
Number of mental health and substance use disorder claims "H" overpayments	4, 952

*The Company explains that this figure is computed by totaling the number of claim overpayments (15,529 + 9,219=24,748) then subtracting 7, 708 claims to account for claims counted more than once as containing overpayments in both medical and surgical and mental health and substance use disorder claims.

The Company also provided the dollar figures associated with these claims:

	2015	**2016**	**2017**
Total $ overpayments by year	$3,638,111.60	$12,909,789.32	$2,323,517.43
Total $ recoupment requests by year	$3,603,311.92	$10,718,418.85	$1,660,748.44
Total $ overpayments collected by year.	$515,896.19	$2,447,766.85	$971,162.81
MED $ overpayments by year	$3,350,491.40	$10,810,065.92	$1,940,408.47

MED $ recoupment requests by year	$3,315,691.72	$8,904,032.57	$1,454,991.65
MED $ overpayments collected by year.	$494,757.88	$2,022,473.55	$922,742.88
MHSUD $ overpayments by year	$3,094,029.70	$10,328,649.85	$1,213,070.95
MHSUD $ recoupment requests by year	$3,080,824.44	$8,794,535.42	$876,981.41
MHSUD $ overpayments collected by year.	$312,533.24	$1,099,767.82	$198,193.65
MHSUD "H" only $ overpayments by year	$2,783,425.53	$8,511,531.52	$64,132.61
MHSUD "H" only $ recoupment requests by year	$2,770,242.97	$7,446,834.22	$11,721.60
MHSUD "H" only $ overpayments collected by year.	$238,802.86	$664,750.92	$3,450.00

MED-medical and surgical claims MHSUD-mental health and substance use disorder claims

B. As reported in Finding 3, in four (4) instances out of 109 paid mental health and substance use disorder claims reviewed, for an error percentage of 3.67%, the Company paid the provider but failed to provide an explanation of benefits (EOB) to the claimant due to the use of the EX code 29T (which references Medicaid in error) caused from miscoding by the Company IT function.

C. As reported in Finding 4, in one (1) instance out of 109 mental health and substance use disorder paid claims reviewed, for an error percentage of 0.92%, the Company failed to impose parity between mental health and substance use disorder benefits and medical and surgical benefits by terms of its policy contrary to the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136. While the Company states that these provisions are not enforced, it failed to maintain proper forms caused from miscoding by the Company IT function.

D. As reported in Finding 11, in three (3) instances out of 17 different policies sold during the examination period, for an error percentage of 17.65%, the Company failed to impose parity between mental health and substance use disorder benefits and medical and surgical benefits relative to nonquantitative treatment limits contrary to the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136. While the Company states that these provisions are not enforced, it failed to maintain proper forms caused from miscoding by the Company IT function. In one of these instances, the Company corrected the form effective January 1, 2016.

In later findings in the examination, further IT errors were discovered. In Finding 12, erroneous coverage notices were sent to groups and in Finding 13 erroneous group premium billings were examined.

These acts were committed or performed with such frequency as to be a general business practice by the Company in failing to adopt and implement reasonable standards for the prompt investigation and processing of claims in violation of Utah Code Annotated *§ 31A-26-301.6(10(d)* and § 31A-26-303(3)(b).

Recommendation: The examiners recommend procedures be implemented to ensure that the Company IT system is properly managed to prevent errors.

Claims:

The Company was requested to provide a list of all medical and surgical claims and mental health and substance use disorder claims during the examination period, to include paid and denied. The Company identified universes of 587,292 paid medical and surgical claims, 135,401 denied medical and surgical claims, 99,916 paid mental health and substance use disorder claims and 89,212 denied mental health and substance use disorder claims. Random and proportional samples of 109 paid and 109 denied files were requested, received and reviewed.

1. Medical and Surgical and Mental Health and Substance Use Disorder Paid Claims-File Review

Finding 3:

In four (4) instances out of 109 paid claims reviewed, for an error percentage of 3.67%, the Company failed to send an explanation of benefits (EOBs). This is a violation of Utah Admin. Code R590-192-8(1).

Item	***Claim No.***
16	302412119
21	326185084
27	354924316
31	389187484

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides explanation of benefits.

Finding 4:

In one (1) instance out of 109 mental health and substance use disorder paid claims reviewed, for an error percentage of 0.92%, the Company failed to impose parity between mental health and substance use disorder benefits and medical and surgical benefits by terms of its policy contrary to the mental

health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136 However, the Company does not enforce these provisions, so the forms are not proper and are misleading. This is a violation of Utah Code Annotated § 31A-21-201(2) and (3).

Item	***Claim No.***
108	201604186207711

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides proper forms that are not misleading.

2. Medical and Surgical and Mental Health and Substance Use Disorder Denied Claims-File Review

Finding 5:

The examiners reviewed twelve claims labeled as urgent care claims within the medical and surgical and mental health and substance use disorder denied claims. In one (1) instance, the claim was a post-service claim where the Company failed to pay or deny the claim within thirty days. This is a violation of Utah Code Annotated § 31A-26-301.6(3)(a).

Item	***Claim No.***
1	201601256029682

Recommendation: The examiners recommend procedures be implemented to ensure that the Company pays or denies post-service claims within thirty days.

Finding 6:

In one (1) instance out of 109 denied claim files reviewed, for an error percentage of 0.92%, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of a claim by sending numerous medical record request for records that had previously been obtained. This is a violation of Utah Code Annotated §31A-26-303(3)(b).

Sample#	***Claim Number***	**Comments**
97	201510226367649	*Medical records were received on 09/2015. However, Request were sent 4 times; 11/21/2015, 12/21/2015, 01/19/2016 and 03/18/2016*

Recommendation: The examiners recommend procedures be implemented to ensure that the Company does not request duplicate medical records.

The Company was also requested to provide a list of all mental health and substance use disorder pharmacy claims during the examination period, to include paid and denied. The Company identified universes of 50,477 paid mental health and substance use disorder pharmacy claims and 24,415 denied mental health and substance use disorder pharmacy claims. Random samples of 109 paid and 109 denied files were requested, received and reviewed.

3. Mental Health and Substance Use Disorder Pharmacy Paid Claims-File Review

No errors were noted.

4. Mental Health and Substance Use Disorder Pharmacy Denied Claims-File Review

Finding 7:

In one (1) instance out of 109 mental health and substance use disorder pharmacy denied claims files reviewed, for an error percentage of 0.92%, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims causing the Company to improperly deny this claim and provide an unreasonable explanation. This is a violation of Utah Code Annotated § 31A-26-301.6(6) and (10)(d) and § 31A-26-303(1), (3)(b) and (3)(e).

Item	***Claim No.***
49	354123285061

Recommendation: The examiners recommend procedures be implemented to ensure that the Company adopts and implements reasonable standards for the prompt investigation and processing of claims.

The Company was also requested to provide a listing of claims during the examination period where the Company requested repayment from the provider. The Company identified a universe of 15,353 recoupment requested claim files. A random sample of 109 files was requested, received and reviewed.

5. Provider Recoupment-File Review

Finding 8:

In one (1) instance out of 109 paid claim files reviewed, for an error percentage of 0.92%, the Company failed to provide notification within 12 months to recover amounts paid to a provider in error. This is a violation of Utah Code Annotated § 31A-26-301.6(14).

Item	***Claim No.***
36	*201601254578554*

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides notification within 12 months to recover amounts paid to a provider in error.

Utilization Review:

The Company was requested to provide a list of all medical and surgical utilization review files and mental health and substance use disorder utilization review files during the examination period. The Company identified universes of 9,667 medical and surgical utilization review files and 1,329 mental health and substance use disorder utilization review files. A random and proportional sample of 116 files was requested, received and reviewed.

Finding 9:

In forty-two (42) instances out of 116 utilization review files reviewed, for an error percentage of 36.21% (or forty-two (42) instances out of 47 pre-service paid claims for an error percentage of 89.36%), the Company failed to provide notice to the claimant of the insurer's benefit decision. This is a violation of Utah Admin. Code R590-192-9(4)(a) and Utah Code Annotated § 31A-26-301.6(7).

In addition, these acts were committed or performed with such frequency as to indicate a general business practice by the insurer in failing to acknowledge and act promptly upon communications about claims and failing to adopt and implement reasonable standards for the prompt investigation and processing of claims. This is a violation of Utah Code Annotated §31A-26-303(3)(a) and (b).

Item	***UR File No.***
2	700754522 03
3	H59806831-00
4	108256693 01
9	700642199 01
12	700740758 06
13	700617733 02
14	700544329
15	700516460
18	700586248 01
20	700594906 01
25	008384351 04
28	010424441 03
31	H76081682-00
32	105148905 02
37	101131999
41	700798682
43	011737440 01
44	H59845921-00
46	011302668 02

47	700046281 03
49	H78225083-00
57	700587658 01
62	007045369 01
65	104707859 01
66	009901607 01
69	101910237 01
70	700484313 01
71	700533263 01
72	H70221446 07
77	H45789217 00
80	700658300 01
81	010424413 03
82	H78225320 00
83	700690773 03
84	700986575 01
85	H59780174 00
86	105763605 01
91	011747344 01
92	H598486 01
93	H30812529 00
101	700777617 02
102	700966563 01

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provide proper notice to the claimant of the benefit decision.

Finding 10:

In one (1) instance out of 116 utilization review files reviewed, for an error percentage of 0.86%, the Company failed to send a resolution letter notifying the patient that treatment was authorized. This is a violation of Utah Admin. Code R590-192-6(1). Finding 17 also reveals resolution letters that failed to reference the correct number of days that treatment was authorized.

Item	***UR ID***
105	70102663101

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides resolution letters referencing the correct number of days that treatment was authorized.

Provider Relations:

The Company was requested to provide processes, procedures and other information related to provider relations. No errors were noted.

Marketing and Sales:

Finding 11:

The Company was requested to provide advertising, marketing and sales material including the summary of benefits and coverage for the seventeen products sold during the examination period. The examiners requested samples of five of those policies. In three (3) instances out of seventeen (17) different policies sold during the examination period, for an error percentage of 17.65%, the Company policies did not impose parity between mental health and substance use disorder benefits and medical and surgical benefits relative to nonquantitative treatment limits contrary to the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136. While the Company does not enforce these provisions, the forms are not proper and are misleading. This is a violation of Utah Code Annotated § 31A-21-201(2) and (3).

Product	***Comment***
UTDZ0003_GRP_CERT	Residential treatment facilities (RTF) are excluded from coverage (Pg.55) but skilled nursing facilities are not excluded from medical surgical coverage.
UTPIP002_MBR_CERT	Residential treatment facilities (RTF) are excluded from coverage (Pg.33) but skilled nursing facilities are not excluded from medical surgical coverage.
UTPIP002_MBR_CERT	Mental health and substance use disorder benefits are restricted to outpatient and office therapy for mental health not to exceed $500 per year (Pg. 13) but medical surgical benefits are not restricted.

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides proper forms that are not misleading.

Finding 12:

The Company provided notice in 2017 to the Utah Insurance Department that transitional coverage would be discontinued for the renewal year 2018 for five small employer groups with forty-two employees. The groups were also notified of the discontinuance of this coverage. However, the groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the groups had an option of continuing their transitional coverage.

Similarly, the groups were also notified of the discontinuance of this coverage for the 2019 renewal year. However, the groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the group had an option of continuing the transitional coverage in the renewal year 2019. As of the February 1, 2019 Company membership report, a total of eleven enrollees with two small groups remained active on transitional coverage.

As a result, the Company made communications that contain false or misleading insurance related information to consumers and provided information to the Commissioner that was inaccurate. This is in violation of Utah Code Annotated § 31A-23a-402(1)(a)(i) and Utah Code Annotated § 31A-2-202(6).

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides information to consumers and the Commissioner that is accurate and not misleading.

Finding 13:

The Company provided notice in December 2018 to the Utah Insurance Department that it identified premium billing discrepancies that occurred when changes were made to employer group dependent or spousal coverage under group medical, dental and vison plans. This change in coverage tier resulted in an overcharge and overpayment of premium. This error impacted 65 groups during the timeframe of January 1, 2006 through April 30, 2018, including the examination period. The billing error was discovered in March 2018 during the review of a customer inquiry. The Company identified $41,152.23 of overpayment of premium and $22,303.06 in interest to the 65 groups. The Company provided letters to the members and groups notifying them of this billing error. The Company provided refunds to all terminated groups and credited the account of active groups. This is in violation of Utah Code Annotated § 31A-23a-402(1)(a)(i).

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides information to consumers that is not misleading.

Pharmacy:

The examiners requested, received and reviewed Company information relating to pharmacy and parity including formularies, protocols, tier structure, comparison between drugs for medical and surgical claims and mental health and substance use disorder claims and utilization management.

Finding 14:

The Company has imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on attention-deficit/hyperactivity disorder (ADHD) medications than are imposed on the medical and surgical medications relating to formulary and non-formulary

design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136.

Recommendation: The examiners recommend procedures be implemented to ensure that the Company does not impose greater benefit limitations on mental health and substance use disorder patients relating to attention-deficit/hyperactivity disorder (ADHD) medications than are imposed on the medical and surgical medications.

Finding 15:

The Company has imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on substance abuse medication (buprenorphine containing products) than are imposed on the medical and surgical opioid pain medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136.

Recommendation: The examiners recommend procedures be implemented to ensure that the Company does not impose greater benefit limitations on mental health and substance use disorder patients relating to substance use disorder medications than are imposed on the medical and surgical opioid pain medications.

Finding 16:

The Company has imposed greater benefit limitations on mental health and substance use disorder patients by involving more restrictions on the brand name category of atypical antipsychotics than are imposed on the brand name category of medical and surgical medications relating to formulary and non-formulary design, tier and cost placement and prior authorization and required prior drug therapy plans. This violates the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136.

Recommendation: The examiners recommend procedures be implemented to ensure that the Company does not impose greater benefit limitations on mental health and substance use disorder patients relating to the brand name category of atypical antipsychotics medications than are imposed on the medical and surgical medications.

Mental Health Parity:

As noted under the claims section of the report, the Company was requested to provide a list of all medical and surgical claims and mental health and substance use disorder paid and denied claims during the examination period. For the purposes of additional parity testing, the mental health and substance use disorder claims were combined by unique claim numbers resulting in universes of 30,866 mental health and substance use disorder paid claims and 18,779 mental health and substance

use disorder denied claims. Random samples of 109 paid and 109 denied files were requested, received and reviewed.

As part of these file reviews, the Company was requested to provide 5 selected files from the paid mental health and substance use disorder claims. For these selected files, the Company provided the claim payment history for the policy period, known as the accumulators. The examiners reviewed these accumulators to determine if all cost shares, maximum out of pocket amounts and claim payments had been properly accounted for.

1. Mental Health and Substance Use Disorder Paid Claims-Parity File Reviews

No errors were noted.

2. Mental Health and Substance Use Disorder Denied Claims-Parity File Reviews

No errors were noted.

3. Associated Mental Health and Substance Use Disorder Files-File Reviews

The examiners tested how the Company treated insureds for mental health and substance use disorder claims across the board for implications relating to parity. The examiners judgmentally selected five insureds who had substantial numbers of medical and surgical claims, as well as claims related to the treatment for mental health and substance use disorders including pharmacy and utilization review. Once the sample was selected, random selection of ten mental health and substance use disorder claims for each insured was made consisting of five treatment claims, three pharmacy claims and two utilization reviews.

No implications for issues specifically related to mental health parity were noted. The claims were adjudicated within timeliness guidelines and all member cost shares such as copayments and deductibles were reported accurately. The claims are described as follows. In addition, resolution letters were not furnished in some of the files as noted in the next finding.

<u>Sample Set # 1 – KLH</u>

Ten claims were reviewed for this adult spouse of subscriber with opioid dependence. The sample set was comprised of:

- five mental health and substance use disorder treatment claims consisting of one emergency room claim, one outpatient claim and three lab claims
- three mental health and substance use disorder pharmacy claims
- two mental health and substance use disorder utilization review claims consisting of an inpatient claim and a partial hospitalization (PHP) claim

<u>Sample Set # 2 – KK</u>

Ten claims were reviewed for this adult subscriber with diagnosis of amphetamine and opioid dependence. The sample set was comprised of:

- five mental health and substance use disorder treatment claims consisting of one outpatient claim and four lab claims
- three mental health and substance use disorder pharmacy claims
- two mental health and substance use disorder utilization review claims consisting of an intensive outpatient (IOP) claim and a partial hospitalization (PHP) claim

Sample Set # 3 – CD

Ten claims were reviewed for this adult subscriber with diagnosis of alcohol dependence, bulimia nervosa, and multiple other diagnoses. The sample set was comprised of:

- five mental health and substance use disorder treatment claims consisting of one diagnostic procedure (electrocardiogram) claim, one residential treatment center (RTC) claim, one medical procedure claim and two lab claims
- three mental health and substance use disorder pharmacy claims
- two mental health and substance use disorder utilization review claims consisting of an inpatient detoxification claim and a partial hospitalization (PHP) claim

Sample Set # 4 – SK

Ten claims were reviewed for this adult subscriber with diagnosis of amphetamine dependence. The sample set was comprised of:

- five mental health and substance use disorder treatment claims consisting of five lab claims
- three mental health and substance use disorder pharmacy claims
- two mental health and substance use disorder utilization review claims consisting of an intensive outpatient (IOP) claim and a partial hospitalization (PHP) claim

Sample Set # 5 – BF

Ten claims were reviewed for this adult subscriber with diagnosis of major depressive disorder and opioid abuse. Of note is the fact that this member belonged to a Special Needs Plan (SNP), a specialized plan offered to individuals who are dual eligible for commercial and Medicaid health insurance benefits. This sample set was comprised of:

- five mental health and substance use disorder treatment claims consisting of one claim for anesthesia for electroconvulsive therapy, one inpatient treatment claim and three lab claims
- three mental health and substance use disorder pharmacy claims
- two mental health and substance use disorder utilization review claims consisting of an intensive outpatient (IOP) claim and a partial hospitalization (PHP) claim

Finding 17:

In three (3) instances out of 10 utilization review files, for an error percentage of 30%, the Company

failed to reference the correct number of days that treatment was authorized in resolution letters. This is a violation of Utah Admin. Code R590-192-6(1)(a). Finding 10 also reveals that the Company failed to send a resolution letter that would have been sent to notify the patient of the determination.

Item	***UR ID***
10	H7625886800
9	H7822517700
9	H7822517400

Recommendation: The examiners recommend procedures be implemented to ensure that the Company provides resolution letters referencing the correct number of days that treatment was authorized.

4. Required Company Testing for Mental Health Parity

No errors were noted.

SUMMARY

Comments included in this report which are significant and requiring special attention are summarized below:

1. The Coordinator's Handbook is dated February 19, 2018 with a requested deadline for material of March 9, 2018. Little, if any, material was provided by the deadline. The Company also failed to timely schedule a pre-examination call requested by the examiners. The Company failed to comply with reasonable requests by the examiners and the untimely responses delayed the examination. This is a violation of Utah Code Annotated § 31A-2-204(5)(a) & (b) and Utah Administrative Code R590-192-11(1).

2. The examination revealed various IT glitches or coding errors resulting in a showing of systemic failure in the management of the Company IT systems. These acts were committed or performed with such frequency as to be a general business practice by the Company in failing to adopt and implement reasonable standards for the prompt investigation and processing of claims in violation of Utah Code Annotated *§ 31A-26-301.6(10(d)* and § 31A-26-303(3)(b).

3. In four (4) instances out of 109 paid claims reviewed, for an error percentage of 3.67%, the Company failed to send an explanation of benefits. This is a violation of Utah Admin. Code R590-192-8(1).

4. In one (1) instance out of 109 mental health and substance use disorder paid claims reviewed, for an error percentage of 0.92%, the Company failed to impose parity between mental health and substance use disorder benefits and medical and surgical benefits by terms of its policy

contrary to the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136. However, the Company does not enforce these provisions, so the forms are not proper and are misleading. This is a violation of Utah Code Annotated § 31A-21-201(2) and (3).

5. The examiners reviewed twelve claims labeled as urgent care claims within the medical and surgical and mental health and substance use disorder denied claims. In one (1) instance, the claim was a post-service claim where the Company failed to pay or deny the claim within thirty days. This is a violation of Utah Code Annotated § 31A-26-301.6(3)(a).

6. In one (1) instance out of 109 denied claim files reviewed, for an error percentage of 0.92%, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of a claim by sending numerous medical record request for records that had previously been obtained. This is a violation of Utah Code Annotated §31A-26-303(3)(b).

7. In one (1) instance out of 109 mental health and substance use disorder pharmacy denied claims files reviewed, for an error percentage of 0.92%, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims causing the Company to improperly deny this claim and provide an unreasonable explanation. This is a violation of Utah Code Annotated § 31A-26-301.6(6) and (10)(d) and § 31A-26-303(1), (3)(b) and (3)(e).

8. In one (1) instance out of 109 paid claim files reviewed, for an error percentage of 0.92%, the Company failed to provide notification within 12 months to recover amounts paid to a provider in error. This is a violation of Utah Code Annotated § 31A-26-301.6(14).

9. In forty-two (42) instances out of 116 utilization review files reviewed, for an error percentage of 36.21% (or forty-two (42) instances out of 47 pre-service paid claims for an error percentage of 89.36%), the Company failed to provide notice to the claimant of the insurer's benefit decision. This is a violation of Utah Admin. Code R590-192-9(4)(a) and Utah Code Annotated § 31A-26-301.6(7). In addition, these acts were committed or performed with such frequency as to indicate a general business practice by the insurer in failing to acknowledge and act promptly upon communications about claims and failing to adopt and implement reasonable standards for the prompt investigation and processing of claims. This is a violation of Utah Code Annotated §31A-26-303(3)(a) and (b).

10. In one (1) instance out of 116 utilization review files reviewed, for an error percentage of 0.86%, the Company failed to send a resolution letter notifying the patient that treatment was authorized. This is a violation of Utah Admin. Code R590-192-6(1). Finding 17 also reveals resolution letters that failed to reference the correct number of days that treatment was authorized.

11. The Company was requested to provide advertising, marketing and sales material including

the summary of benefits and coverage for the seventeen products sold during the examination period. The examiners requested samples of five of those policies. In three instances out of 17 different policies sold during the examination period, for an error percentage of 17.65%, the Company policies did not impose parity between mental health and substance use disorder benefits and medical and surgical benefits relative to nonquantitative treatment limits contrary to the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136. However, the Company does not enforce these provisions, so the forms are not proper and are misleading. This is a violation of Utah Code Annotated § 31A-21-201(2) and (3).

12. The Company provided notice in 2017 to the Utah Insurance Department that transitional coverage would be discontinued for the renewal year 2018 for five small employer groups with forty-two employees. The groups were also notified of the discontinuance of this coverage. However, the groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the groups had an option of continuing their transitional coverage. Similarly, the groups were also notified of the discontinuance of this coverage for the 2019 renewal year. However, the groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) - compliant plan and a letter indicating the group had an option of continuing the transitional coverage in the renewal year 2019. As of the February 1, 2019 Company membership report, a total of eleven enrollees with two small groups remained active on transitional coverage. As a result, the Company made communications that contain false or misleading insurance related information to consumers and provided information to the Commissioner that was inaccurate. This is in violation of Utah Code Annotated § 31A-23a-402(1)(a)(i).

13. The Company provided notice in December 2018 to the Utah Insurance Department that it identified premium billing discrepancies that occurred when changes were made to employer group dependent or spousal coverage under group medical, dental and vison plans. This change in coverage tier resulted in an overcharge and overpayment of premium. This error impacted 65 groups during the timeframe of January 1, 2006 through April 30, 2018, including the examination period. The billing error was discovered in March 2018 during the review of a customer inquiry. The Company identified $41,152.23 of overpayment of premium and $22,303.06 in interest to the 65 groups. The Company provided letters to the members and groups notifying them of this billing error. The Company provided refunds to all terminated groups and credited the account of active groups. This is in violation of Utah Code Annotated § 31A-23a-402(1)(a)(i).

14. The Company has imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on attention-deficit/hyperactivity disorder (ADHD) medications than are imposed on the medical and surgical medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136.

15. The Company has imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on substance abuse medication (buprenorphine containing products) than are imposed on the medical and surgical opioid pain medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136.

16. The Company has imposed greater benefit limitations on mental health and substance use disorder patients by involving more restrictions on the brand name category of atypical antipsychotics than are imposed on the brand name category of medical and surgical medications relating to formulary and non-formulary design, tier and cost placement and prior authorization and required prior drug therapy plans. This violates the mental health parity laws including Utah Code Annotated § 31A-22-625, 42 U.S.C § 300gg–26 and 45 C.F.R. 146.136.

17. In three (3) instances out of 10 utilization review files, for an error percentage of 30%, the Company failed to provide resolution letters referencing the correct number of days that treatment was authorized. This is a violation of Utah Admin. Code R590-192-6(1)(a). Finding 10 also reveals a resolution letter that failed to reference the correct number of days that treatment was authorized.

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

In addition to the undersigned, Shelly Schuman, Jo Sitter, Lonnie Suggs, Kirk Stephan, Art Kusserow, Andre Mumper-Ham, George Lentini and other Utah Insurance Department personnel assisted in the examination.

Joe Cohen
Market Conduct Examiner-in-Charge
The INS Companies